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IN THE

Supreme Court of the United States

KELLY A. AYOTTE,
ATTORNEY GENERAL OF NEW HAMPSHIRE, *et al.*,
Petitioners,

v.

PLANNED PARENTHOOD
OF NORTHERN NEW ENGLAND, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, NEW HAMPSHIRE MEDICAL SOCIETY, AMERICAN ACADEMY OF PEDIATRICS, NEW HAMPSHIRE PEDIATRIC SOCIETY, SOCIETY FOR ADOLESCENT MEDICINE, AMERICAN PSYCHIATRIC ASSOCIATION, NORTH AMERICAN SOCIETY OF ADOLESCENT AND PEDIATRIC GYNECOLOGY, NATIONAL MEDICAL ASSOCIATION, AND AMERICAN PUBLIC HEALTH ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTERESTS OF *AMICI* [1]

The leading medical and public health associations in the United States submit this brief as *amici curiae* to explain why the failure of the New Hampshire Parental Notification Prior to Abortion Act (the "Act") to provide an exception for medical emergencies significantly jeopardizes minors' health and why the Act interferes with physicians' legal and ethical obligations to protect their patients' health. This brief includes technical information about specific medical conditions to illustrate the threat to adolescent health posed by the Act.

The **American College of Obstetricians and Gynecologists** ("ACOG") is a non-profit educational and professional organization founded in 1951. With more than 45,000 members in the United States, ACOG is the leading professional association of physicians who specialize in the health care of women. ACOG recognizes that the issue of support for or opposition to abortion is a matter of profound moral conviction to its members. ACOG, therefore, respects the need and responsibility of its members to determine their individual positions on abortion based on personal values or beliefs. As an organization, ACOG opposes unnecessary regulations that limit or delay access to medical care, including abortion. Many of ACOG's members treat pregnant minors facing health emergencies.

The **American Medical Association** ("AMA"),[2] an Illinois non-profit corporation, is an association of approxi-

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[1] No counsel for a party authored this brief in whole or in part, and no person or entity other than *amici* and their counsel made any monetary contribution toward the preparation or submission of this brief. Letters indicating the parties' consent to the filing of this *amicus* brief have been submitted to the Clerk.

[2] The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, non-profit state medical so-

mately 250,000 physicians, residents, and medical students and is the largest medical society in the United States. Its members practice in every state, including New Hampshire, and in every field of medical specialization. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes.

The **New Hampshire Medical Society** ("NHMS"), a New Hampshire not-for-profit organization incorporated in 1791, represents approximately 2,000 physicians, residents, and medical students within New Hampshire. Its objectives are to promote the science and art of medicine and the betterment of public health within New Hampshire. It seeks to attain these objects by federating and bringing into one compact state organization every physician licensed to practice medicine in the state, by participating in the processes of government at all levels, and by uniting with similar societies as a constituent of the AMA.

Neither the AMA nor the NHMS support or oppose abortion. Both the AMA and the NHMS believe that this issue is a matter for physicians to decide individually, based on personal values and beliefs.[3] The AMA and the NHMS join this brief to support the integrity and confidentiality of the patient/physician relationship and the ethical duty of physicians to respect and advocate for their patients' personal autonomy. They also join this brief because they oppose the imposition of criminal penalties on health care decision-making.

The **American Academy of Pediatrics** ("AAP"), founded in 1930, is a non-profit professional organization of pediatricians, pediatric medical subspecialists, and pediatric

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cieties, including the New Hampshire Medical Society, to represent the views of organized medicine in the courts.

[3] *See* American Medical Association, H-5.990: *Policy on Abortion*, *available at* http://www.ama-assn.org/ama/noindex/category/11760.html. This resolution was adopted by the AMA's House of Delegates, the primary policy-making body of the AMA.

surgical specialists, with more than 60,000 members. Its mission is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults, including those who are pregnant.

The **New Hampshire Pediatric Society** ("NHPS"), founded in 1957, is a state chapter of the American Academy of Pediatrics. Its membership consists of over 200 physicians from across the state. Like the AAP, NHPS is dedicated to the optimal physical, mental, and social health and well-being of all infants, children, adolescents, and young adults, including those who are pregnant.

The **Society for Adolescent Medicine** ("SAM") is a multi-disciplinary organization composed of health-care professionals who dedicate their lives to the care of adolescents. SAM works to promote public and professional awareness of the health-related needs of adolescents and to promote the health and well-being of all adolescents. Members of SAM treat pregnant minors who face health emergencies.

The **American Psychiatric Association** ("APA"), with approximately 40,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA has long opposed legal interference with abortion rights and with physicians' exercise of their medical judgment to protect their patients' health.

The **North American Society for Pediatric and Adolescent Gynecology** ("NASPAG") is a non-profit association comprised obstetrician-gynecologists, adolescent medicine specialists and other pediatricians, family practitioners, and nurse practitioners. NASPAG acts as a forum for education, research, and communication among health professionals who provide gynecologic care to children and adolescents.

The **National Medical Association** ("NMA") is the nation's oldest and largest organization representing African-American physicians and health professionals in the United States. Established in 1895, the NMA is the collective voice of more than 25,000 African American physicians and the patients they serve. The NMA promotes the interests of physicians and patients of African descent and carries out

this mission by promoting parity in medicine, elimination of health disparities, and promotion of optimal health.

Founded in 1872, the **American Public Health Association** ("APHA") is the oldest, largest, and most diverse organization of public health professionals in the world. The association works to protect all Americans, their families, and communities from preventable, serious health threats and strives to ensure that community-based health promotion, injury and disease prevention activities, and preventive health services are universally accessible. APHA represents a broad array of health officials, educators, environmentalists, policy-makers, and health providers at all levels, working both within and outside governmental organizations and educational institutions.

INTRODUCTION AND SUMMARY OF ARGUMENT

Notwithstanding the assertions of New Hampshire and many of its *amici*, this case is not about the wisdom of laws requiring mandatory notice to a minor's parent when she seeks an abortion. Whatever one may think about such laws, this case is about an altogether different issue: whether, when such a law exists, it should apply even in situations where the time it takes to comply with its notification requirement, or to seek a court's permission not to do so, will place a young woman's health in grave danger. As the leading medical and public health organizations representing physicians who treat pregnant women in this country, *amici* urge this Court to answer that question in the negative. No law, regardless of its justification, should be permitted to place a patient's health at risk. But this is precisely what New Hampshire's Parental Notification Prior to Abortion Act (the "Act") does.

Contrary to more than thirty years of this Court's precedents declaring that women's health is, and must be, paramount when the government regulates abortion, New Hampshire has passed a statute that places the State's pregnant minors at serious risk. And the State and its *amici* now attempt to insulate that statute from challenge by urg-

ing a standard for judicial review that will effectively deny timely abortions to critically ill minors facing medical emergencies by prohibiting facial challenges to that law. The Court should reject their efforts.

First, the failure to include a medical-emergency exception in the Act jeopardizes the health of New Hampshire minors, some of whom will have conditions that will require immediate abortions to protect their health. For these minors, even the relatively short delay mandated by the Act to notify the minor's parents or seek court relief will have catastrophic health consequences. Parental notice is not necessary to provide safe abortion care to a minor. Also, the Act would force physicians to violate ethical and professional obligations by requiring them to delay critical treatment in a medical emergency.

Second, requiring a specific patient to bring an as-applied challenge to a law lacking a medical-emergency exception will put women at risk. Such challenges provide no meaningful relief to physicians and patients when there is a need for immediate treatment. Statutory medical-emergency exceptions of uniform applicability—not case-by-case relief—are the only adequate means of safeguarding physician judgment and preserving women's health in an emergency context.

Finally, the Act's death exception is inadequate to protect even those pregnant minors who face life-threatening emergencies.

ARGUMENT

I. The Act's Failure To Include an Exception for Medical Emergencies Significantly Jeopardizes Minors' Health

New Hampshire's Parental Notification Prior to Abortion Act (the "Act"), which requires that a minor's parent be notified in writing at least forty-eight hours before an abor-

tion is performed,[4] contains no exception whatsoever for situations in which a pregnant minor faces a medical emergency that requires an immediate abortion to preserve her health, even though the majority of states permit physicians to render care without parental consent in other medical emergencies. This omission places young women at significant risk. The medically indicated treatment for some serious medical conditions that arise during pregnancy—including certain hypertensive disorders, infections, and placental anomalies—may be the prompt termination of the pregnancy. But the Act prohibits New Hampshire physicians from providing that medically indicated treatment. Instead, under threat of criminal penalties, they must delay care until forty-eight hours after providing written notice to the minor's parent or until a court hears and grants the minor's bypass petition. This state of affairs would violate the central tenets of proper obstetrical and emergency health care, conflict with physicians' ethical and professional obligations, and unconscionably endanger minors' health.

A. New Hampshire Minors Will Require Immediate Abortions To Protect Their Health in Circumstances That Would Not Be Covered by the Act's Death Exception

1. Physicians who treat pregnant minors encounter patients who face serious health complications that require immediate abortions

Physicians who treat pregnant women, including pregnant minors, encounter patients with serious health conditions that would not qualify for the Act's death exception. These conditions are nevertheless so severe that immediate termination of the pregnancy will, in some instances, be the

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[4] *See* N.H. Rev. Stat. Ann. § 132:25 (2004) ("No abortion shall be performed upon an unemancipated minor ... until at least 48 hours after written notice of the pending abortion has been delivered ...."). No delay is mandated if a parent certifies that he or she has been notified. *Id.* § 132:26.

medically indicated course of treatment, and the delay mandated by the Act would place the patient at serious risk. Such conditions include:

Hypertensive Disorders of Pregnancy. Pregnancy-induced hypertensive disorders (characterized by a pregnant woman's blood pressure rising above 140/90 mm Hg with or without an occurrence of high blood pressure before pregnancy) remain one of the leading causes of maternal morbidity.[5] Hypertensive diseases occurring during pregnancy include preeclampsia, eclampsia, and HELLP syndrome.[6] These are all grave disorders that often require the immediate termination of the pregnancy to prevent potentially catastrophic health consequences, but may not qualify for the Act's death exception.

Preeclampsia is a clinical hypertensive disorder characterized by high blood pressure, kidney dysfunction, and swelling. (It is the precursor to eclampsia, which is marked by the occurrence of seizures in women with preeclampsia.[7]) Women with severe preeclampsia can face serious deterioration of a number of organs and organ systems.[8] Renal failure, blindness, congestive heart failure, myocardial infarction (heart attack), pulmonary edema (fluid accumulation and swelling in the lungs), rupture of the liver, and stroke are all known maternal health risks associated with severe preeclampsia.[9]

When severe preeclampsia is diagnosed, "immediate delivery, regardless of gestational age" is routinely recom-

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[5] *Harwood-Nuss' Clinical Practice of Emergency Medicine* 508-509 (Allan Wolfson et al. eds., 4th ed. 2005).

[6] *Williams Obstetrics* 568, 579 (F. Gary Cunningham et al. eds., 21st ed. 2001); Karin Zetterstrom et al., *Maternal Complications in Women With Chronic Hypertension: A Population-Based Cohort Study*, 84 Acta. Obstet. Gynecol. Scand. 419, 419-424 (2005).

[7] *Williams Obstetrics* 571.

[8] *Id.* at 573.

[9] *Id.* at 573-585.

mended.[10] Where the fetus is not yet viable, this means abortion.[11] Indeed, delaying termination of the pregnancy is associated with increased maternal morbidity and complications including placental abruption (premature separation of the placenta with excess bleeding), eclampsia, coagulopathy (inability of blood to clot), hypertensive encenphalopathy, renal failure, intracerebral hemorrhage, and ruptured hepatic hematoma (formation of a blood clot in the liver that can rupture into the abdomen causing internal hemorrhage and/or uncontrolled blood loss).[12] Such complications can lead to life long pain and suffering for the woman.

HELLP syndrome, a complication unique to pregnancy-induced hypertension, is characterized by a triad of hemolysis (disintegration of red blood cells), elevated liver enzymes,

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[10] *Critical Care Obstetrics* 438 (Gary A. Dildy III et al. eds., 4th ed. 2004); *see Harwood-Nuss' Clinical Practice of Emergency Medicine* 510 ("In cases where there is evidence of advanced disease or of impending eclampsia, delivery is indicated, regardless of the age of the fetus. In these cases, evacuation of the uterus is the only measure that will halt the advance of the disease.").

[11] Many of the leading obstetrics and emergency medicine texts, in discussing the medically indicated treatment for women facing serious health conditions, refer to the need for "prompt delivery" or "immediate delivery, regardless of gestational age." *See, e.g., Critical Care Obstetrics* 438. The State's *amici* seize on this language to argue that an *abortion* is not indicated in the face of certain medical conditions, but rather that *delivery* of the fetus is the appropriate treatment. *See, e.g.*, Pro-Life Ob/Gyns Br. 14, 16. This is a false distinction. "Delivery" of a fetus before the point of viability (when the fetus can survive outside the woman on its own or with artificial assistance) *is* an abortion. *See Williams Obstetrics* 856 (Abortion is the "termination of pregnancy by any means before the fetus is sufficiently developed to survive."); N.H. Rev. Stat. Ann. § 132:24 (Supp. 2004) ("'Abortion' means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a female known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove an ectopic pregnancy or the products from a spontaneous miscarriage.").

[12] *Critical Care Obstetrics* 438.

and low platelets.[13] HELLP develops in 5% to 20% of women with preeclampsia/eclampsia.[14] Complications associated with HELLP syndrome include placental abruption, acute renal failure, and hepatic hematoma with rupture.[15] The indicated treatment for a patient who develops HELLP in almost all cases is immediate termination of the pregnancy (abortion pre-viability and delivery post-viability), especially if she exhibits uncontrolled blood pressure or signs of changes in liver enzymes (which indicate a deterioration in health).[16] With any of these hypertensive disorders of pregnancy, the mandatory delay required by the Act to notify a minor's parent or obtain a court bypass could seriously endanger and possibly permanently impair the patient's health.

Preterm Premature Rupture of Membranes and Chorioamnionitis. Preterm premature rupture of membranes ("PPROM") is the rupture of the membranes that bathe the fetus at any time prior to 37 weeks gestational age.[17] PPROM can occur early in pregnancy.[18] When such rupture occurs, the risk of developing chorioamnionitis, a serious infection of the placental lining and fluids, increases dramatically.[19] Chorioamnionitis can also occur spontaneously in the absence of PPROM, and can occur when an in-

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[13] *Williams Obstetrics* 579.

[14] *Id.* (noting incidence as high as 20%); *Critical Care Obstetrics* 449 (noting average incidence of 12%); *Emergency Medicine: Concepts and Clinical Practice* 2353 (Peter Rosen et al. eds., 1998) (HELLP develops in 5-10% of women with preeclamptic symptoms).

[15] *Critical Care Obstetrics* 450.

[16] *Id.* at 450-451.

[17] *Harwood-Nuss' Clinical Practice of Emergency Medicine* 517.

[18] Lee C. Yang et al., *Maternal and Fetal Outcomes of Spontaneous Preterm Premature Rupture of Membranes*, 104 J. Am. Osteopathic Ass'n 537, 537-542 (2004).

[19] *Id.*; *Emergency Medicine* 1321 (John M. Howell et al. eds., 1998)

fection results from, for example, amniocentesis (the removal of amniotic fluid, usually for chromosomal testing).[20]

The onset of chorioamnionitis places the patient at serious risk of severe harms that compound on each other, including permanent infertility and sepsis (infection affecting one or more major bodily organs, such as the lungs, liver, kidney, heart, or brain).[21] PPROM with evidence of infection "dictates delivery regardless of gestational age."[22] In cases of PPROM and chorioamnionitis, the mandatory delay imposed by the Act (to effectuate parental notice or obtain a judicial bypass) may seriously jeopardize the patient's health.

Placental Abruption and Placenta Previa. Placental abruption is the complete or partial separation of the placenta from the uterine wall. Maternal risks associated with abruption include massive blood loss requiring red cell transfusion, disseminated intravascular coagulation ("DIC"), and kidney failure;[23] these associated conditions can lead to acute respiratory distress syndrome ("ARDS") and death.[24] Among the most serious immediate complications of placental abruption is DIC. DIC is a disorder associated with a host of serious conditions and results in the inability to form a clot with the consequence of uncontrolled bleeding.[25] The occurrence of DIC increases the ongoing risk of hemorrhage and makes the heavy bleeding more difficult to treat. In-

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[20] *Medical Complications During Pregnancy* 314-315 (Gerard N. Burrow et al. eds., 6th ed. 2004).

[21] *Critical Care Obstetrics* 562-564; Paul L. Marino, *The ICU Book* 503-505 (1998); *see also* Decl. of Wayne Goldner, M.D. ¶ 10.

[22] *Emergency Medicine* 1322; *see also* Pro-Life Ob/Gyns Br. 16 (treatment of chorioamnionitis requires prompt "delivery").

[23] Cande V. Ananth et al., *Placental Abruption in the United States, 1979 through 2001: Temporal Trends and Potential Determinants*, 192 Am. J. of Obstet. & Gynecol. 191, 192 (2005).

[24] *Id.*; *Critical Care Obstetrics* 335.

[25] *Emergency Medicine: Concepts and Clinical Practice* 2377; *Critical Care Obstetrics* 399.

creased bleeding signals an escalating threat to the patient's health. In such circumstances, an emergency abortion may be required before the delay in care that the Act mandates for parental notification or judicial bypass.[26]

Placenta previa exists when the placenta partially or entirely covers the cervical os (opening). As with placental abruption, the gravest risk associated with placenta previa is excessive bleeding.[27] When cases of central or total previa occur, the risk of severe hemorrhage rises and "may become life-threatening in as little as 15 min[utes]."[28] While most cases of placenta previa do not require pregnancy termination, in some cases, severe hemorrhage from placenta previa will necessitate an emergency abortion.[29] For those patients, even a moderate delay in treatment poses serious health risks.

2. The frequency of these conditions is irrelevant both to the constitutional inquiry and to the medical necessity of an emergency exception

Contrary to the State's claims, *see* Pet. Br. 13-16, the relative rarity of these health conditions does not obviate the need for a medical-emergency exception in the Act. This Court has repeatedly noted that a medical condition's infrequency is irrelevant to whether a health exception is necessary in a law regulating abortion—and for good reason. It is

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[26] *Harwood-Nuss' Clinical Practice of Emergency Medicine* 497 (evacuation of uterus may be needed when massive blood loss occurs); *Critical Care Obstetrics* 298-299 (life threatening blood loss can occur with abruption leading to need to expedited delivery).

[27] *Emergency Medicine: Concepts and Clinical Practice* 2352; Takashi Yamada et al., *Case Report: Two Cases of Placenta Previa Terminated at 18 Weeks' Gestation*, 49 Kobe J. Med. Sci. 51, 51-54 (2003).

[28] L.G. Johnson et al., *The Relationship of Placenta Previa and History of Induced Abortion*, 81 Int'l J. Gynec. & Obstet. 191, 191 (2003).

[29] Yamada et al., *supra* note 27, at 51-54; *see also* Pro-Life Ob/Gyns Br. 16 (noting that "delivery" is the appropriate treatment for certain cases of placenta previa).

of no comfort to the pregnant minor facing a medical emergency, or to the physician treating her, that most women have uncomplicated pregnancies and thus would never have to avail themselves of a medical-emergency exception. Thus, in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000), this Court acknowledged that "the health exception question is whether protecting women's health requires an exception for those infrequent occasions."[30] The Court continued: "A rarely used treatment might be necessary to treat a rarely occurring disease that could strike anyone—the State cannot prohibit a person from obtaining treatment simply by pointing out that most people do not need it."[31]

Similarly, in *Thornburgh* v. *American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), this Court held that a medical-emergency exception was required in circumstances that were comparatively rare. There, the Court invalidated a statute that would have required the participation of two physicians in any post-viability abortion because it failed to contain an exception for medical emergencies.[32] Yet it would have been a rare situation indeed in which waiting for a second concurring physician to arrive would have itself posed a health risk to the patient.

By definition, medical-emergency exceptions are intended to address the atypical scenario. This Court has nevertheless regularly required them in statutes that regulate abortion because it has insisted that women's health remain paramount when the state enacts such statutes. *See Planned Parenthood* v. *Casey*, 505 U.S. 833, 880 (1992) ("the

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[30] *Stenberg* v. *Carhart*, 530 U.S. 914, 934 (2000).

[31] *Id.*; *see also Planned Parenthood of Wisconsin* v. *Doyle*, 162 F.3d 463, 469 (7th Cir. 1998) (the fact that the abortion procedure at issue is rare is irrelevant because "[a] woman whose health depends on it will not be comforted to learn that Wisconsin has decided to ban the procedure because only a few women need it and so the state can make a low-cost statement of opposition to abortion rights").

[32] *Thornburgh* v. *American Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 771 (1986).

essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health"). The Act violates this core principal by subordinating the health of minors facing certain medical emergencies.

3. These health conditions, even if relatively uncommon, affect substantial numbers of pregnant women, including pregnant minors

There is no real dispute that while these conditions occur with relative infrequency, they afflict substantial numbers of pregnant women, including pregnant minors, each year. Contrary to the State's suggestion, *see* Pet. Br. 13, these emergency health conditions are not merely hypothetical scenarios. Physicians who treat pregnant women, including members of *amici* medical organizations, treat patients facing these health emergencies. In some of these cases, emergency abortions will be the most medically appropriate response.[33]

Indeed, in *Casey*, this Court recognized that both preeclampsia and PPROM occur during pregnancy and that they present the risk of serious injury in some cases when the pregnancy is not terminated.[34] Current statistics bolster these findings:

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[33] The State's *amicus*, the Thomas More Society, attempts to marshal statistics to prove that emergency abortions do not occur. Its analysis is suspect, however, because only six states require reporting of cases in which an exception was relied on to excuse compliance with a parental involvement law. *Cf.* Stanley K. Henshaw & Dina J. Feivelson, *Teenage Abortion and Pregnancy Statistics by State, 1996*, 32(6) Family Planning Perspectives 272, 272-273 (2000) (noting limitations of CDC data on abortion due to incomplete reporting by many states). But even in those six states, thirteen instances were reported in which a physician utilized a medical-emergency exception. *See* Thomas More Soc'y Br. 12-22. Of course, these are not necessarily the only instances in which a minor required an emergency abortion to protect her health in those states.

[34] 505 U.S. at 978.

- Estimates of occurrence of PPROM range from 3% of all pregnancies[35] to 8% of all pregnancies.[36] Clinical chorioamnionitis has been reported in 0.5% to 3.0% of all pregnancies.[37] Thus, chorioamnionitis occurs in approximately 31,500 to 189,000 of the 6.3 million pregnancies in the United States each year, some number of which will be in minors.[38]
- Approximately 6% to 8% of pregnancies are complicated by hypertensive disorder of pregnancy.[39] The incidence of preeclampsia among all women is approximately 5%, or approximately 315,000 pregnancies per year.[40] HELLP syndrome, a variant of severe preeclampsia, affects 12% of patients with preeclampsia, or approximately 37,800 women per year.[41]
- Placental abruption is estimated to occur in approximately 1 in 200 pregnancies, or approximately 31,500 pregnancies per year.[42] Moreover, placental abruption in women with HELLP syndrome is 20 times more likely than in the general obstetric population.[43]

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[35] *Emergency Medicine: Concepts and Clinical Practice* 2375; Timothy Canavan et al., *An Evidence-Based Approach to the Evaluation and Treatment of Premature Rupture of Membranes*, 59 Obstet. & Gynecol. Survey 669, 669 (2004).

[36] *Harwood-Nuss' Clinical Practice of Emergency Medicine* 517.

[37] Vaughn I. Rickert et al., *Prevalence and Risk Factors of Chorioamnionitis Among Adolescents*, 92 Obstet. & Gynecol. 254, 254 (1998).

[38] Alan Guttmacher Institute, *Facts in Brief: Induced Abortion in the United States* (2005) ("Induced Abortion"), *available at* http://www.agi-usa.org/pubs/fb_induced_abortion.html.

[39] *Critical Care Obstetrics* 436.

[40] *Williams Obstetrics* 572.

[41] *Critical Care Obstetrics* 448.

[42] *Williams Obstetrics* 622.

[43] *Critical Care Obstetrics* 450.

- Placenta previa is present in 1 in 200 to 1 in 390 pregnancies.[44]

Minors are not immune from these serious conditions, which affect teens and adult women alike. As the district court below noted, "the parties do not dispute that pregnant minors, subject to the requirements of the Act, could experience complications in their pregnancies that would endanger their health."[45] Indeed, the State's *amici* concede that "potentially catastrophic medical conditions" such as "preeclampsia/eclampsia, premature rupture of the membranes/chorioamnionitis, placenta previa and abruptio placenta" do affect pregnant minors.[46] Moreover, New Hampshire's decision to include a death exception in the Act evinces a recognition that medical complications that would require an immediate abortion can threaten the health and lives of young women, otherwise such an exception would not be necessary.

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[44] *Williams Obstetrics* 631.

[45] 296 F. Supp. 2d 59, 65 n.4 (D.N.H. 2003) (noting that Dr. Wayne Goldner "describ[ed] medical complications which may occur during pregnancy putting pregnant minors at risk and requiring prompt or immediate termination of the pregnancy"); *Planned Parenthood* v. *Owens*, 107 F. Supp. 2d 1271, 1277 (D. Colo. 2000) (noting that some minors "will experience medical conditions during pregnancy that pose serious risks to their health ... [t]hese conditions include preeclampsia [and] premature rupture of membranes ... [s]ome of these conditions require immediate attention to avoid risk of serious health problems or even death. Preeclampsia, for example, calls for immediate action as delay can place the woman at risk for cerebral hemorrhage, liver failure, kidney failure, vision problems and coma. Therefore, when a pregnant minor presents with one of these urgent medical conditions, delaying aggressive treatment in order to give notice pursuant to the Act may place the patient's health at risk in circumstances short of imminent death.") (internal citations omitted); *see also Planned Parenthood* v. *Wasden*, 376 F.3d 908, 926-927 (9th Cir. 2004) (medical conditions such as preeclampsia and HELLP syndrome may necessitate an emergency abortion).

[46] *See* Pro-Life Ob/Gyns Br. 9-17; *see also* Thomas More Soc'y Br. 12-22 (noting that medical emergency abortions have been reported in Alabama, Nebraska, and Wisconsin).

In fact, pregnant minors face an *increased* risk of some specific conditions when compared with adult women.[47] This is due, in part, to the fact that these conditions more often affect women with poor or non-existent prenatal care.[48] Minors, and especially the youngest minors, are the least likely group of women to receive timely, if any, prenatal care.[49] Delayed prenatal care can lead to delayed diagnosis and treatment of conditions complicating pregnancy, and thus higher risks of complications and more advanced disease progression. For example, rates of eclampsia, the most severe form of hypertension in pregnancy, are higher in women who have not received appropriate prenatal treatment.[50]

Minors are also at higher risk for specific emergency medical conditions. For example, minors are more likely to be infected with a sexually transmitted disease, such as chlamydia or gonorrhea, than are adult women.[51] Both gonorrhea and chlamidya are associated with increased risk of PPROM, and thus could lead to chorioamnionitis.[52] Indeed, there is evidence of increased risk of chorioamnionitis among adolescents.[53]

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[47] Jonathan D. Klein et al., *Adolescent Pregnancy: Current Trends and Issues*, 116 Pediatrics 281, 283 (2005). In fact, the mortality rate for young pregnant women is twice that of adult pregnant women. *Id.*

[48] *Id.* at 283.

[49] *See* Fay Menacker et al., *Births to 10-14 Year-Old Mothers, 1990-2002: Trends and Health Outcomes*, 53 Nat'l Vital Stat. Rep. (2004), *available at* http://www.cdc.gov/nchs/births.htm.

[50] *Harwood-Nuss' Clinical Practice of Emergency Medicine* 508.

[51] CDC, *STD Surveillance 2003: Adolescents and Young Adults* (2003), *available at* http://www.cdc.gov/std/stats/adol.htm; Alan Guttmacher Institute, *Facts in Brief: Teen Sex and Pregnancy* (1999), *available at* http://www.agi-usa.org/pubs/fb_teen_sex.html.

[52] *Medical Complications During Pregnancy* 319-321; *ACOG Practice Bulletin: Premature Rupture of Membranes* (1998).

[53] Rickert et al., *supra* note 37, at 254-257.

Women at the extreme ends of the reproductive age spectrum—and thus, minors—are also most susceptible to pregnancy associated hypertension.[54] The risk of pregnancy-induced hypertension is greatest in women younger than 20;[55] in fact, rates of pregnancy-associated hypertension for the youngest teens is more than 40% higher than rates among older women.[56] Preeclampsia is primarily a disorder of first pregnancies;[57] it is thus especially prevalent among women under the age of 19.[58]

These statistics demonstrate that, far from being hypothetical, these health emergencies can occur with reasonable frequency in all women, including, and in some cases especially, in adolescents.[59] Their relative infrequency does nothing to diminish the need to treat them appropriately when they do occur.

B. The Act's Judicial Bypass Mechanism Is Insufficient To Protect Minors Who Need Emergency Abortions To Protect Their Health

Contrary to New Hampshire's assertions, the Act's judicial bypass option does not negate the need for a health exception, as it does not address situations in which a minor needs emergency medical care before a bypass can be granted. Even very short delays can be catastrophic in a

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[54] *Williams Obstetrics* 572.

[55] *Emergency Medicine: Concepts and Clinical Practice* 2353.

[56] *See* Menacker et al., *supra* note 49.

[57] *ACOG Practice Bulletin: Diagnosis and Management of Preeclampsia and Eclampsia* 2 (2002).

[58] Sinan Ozalp et al., *Health Risks For Early (≤19) and Late (≥35) Childbearing*, 268 Arch. Gynecolol. Obstet. 172, 172-174 (2002).

[59] Minnesota claims that Minnesota teens have not suffered harm despite that state's lack of a medical-emergency exception in its parental involvement law. Minn. Br. 9. The statistics it cites to support this proposition, however, address only complications that occurred during abortion procedures (*see id.* App. 1), which demonstrate nothing about minors whose health may have been compromised by a delay in abortion care necessitated by compliance with the state's parental notice requirement.

medical emergency. Some complications resulting from emergency conditions can be minimized by aggressive, early intervention to terminate the pregnancy. Conversely, even a short delay in diagnosis and effective treatment in certain circumstances can lead to increased rates of maternal morbidity. For example, delay in the treatment of chorioamnionitis can lead to widespread infection, including septic shock, and an increased risk of placental abruption.[60] Likewise, even apparently mild preeclampsia can rapidly progress to the most severe forms of pregnancy-induced hypertension. When preeclampsia is severe, delaying termination of the pregnancy—even for the time necessary to obtain a court order—can be calamitous, causing placental abruption, eclampsia, renal failure, hemorrhage, and stroke.[61]

Moreover, because medical conditions are inherently unpredictable and change frequently, it is impossible to forecast with certainty when a serious health condition will rise to the level of a catastrophic condition.[62] A minor's condition can rapidly deteriorate; in the face of such decline, physicians must have the ability to act quickly to protect their patient's health.[63] The judicial bypass process, even if operated with dispatch, simply will not be fast enough in some cases.

New Hampshire is simply wrong when it suggests that courts are the routine forum for determining treatment options in a medical emergency. *See* Pet. Br. 22 & n.4. Courts

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[60] *Critical Care Obstetrics* 298, 562-564.

[61] *Williams Obstetrics* 594, 623-624; *Critical Care Obstetrics* 437; Zetterstrom et al., *supra* note 6, at 419-424.

[62] *See* 390 F.3d 53, 63 (1st Cir. 2004) ("[P]hysicians cannot predict with adequate precision what course medical complications will take, and thus cannot always determine whether death will occur within this time window."); *Critical Care Obstetrics* 3.

[63] *Critical Care Obstetrics* 3 ("[I]t may be helpful to consider critical illness as impending, developing, or established significant organ dysfunction, which may lead to long-term morbidity or death. This allows some flexibility in the characterization of disease severity since it recognizes conditions that can deteriorate rather quickly in pregnancy.").

rarely became involved in medical decision-making; the examples provided by the State, such as blood transfusion of Jehovah's Witness, are the exception, not the rule. Successful outcomes depend in many cases on physicians' ability to act immediately in a medical emergency.

C. The Act Imposes Inappropriate Ethical and Practical Burdens on Physicians

The Act places physicians at odds with their professional obligations to their patients. It violates basic principles of medical ethics to require a doctor to "wait and see" if a minor patient's condition deteriorates into a life-threatening situation before permitting that doctor to provide medically indicated treatment. Yet this is precisely what the Act demands. It exposes physicians to criminal and civil penalties for meeting their ethical and professional obligations to treat patients according to their best medical judgment in emergent situations. It also deprives patients of their fundamental right to optimal, confidential medical care without governmental interference.[64]

The Act imposes a practical burden on physicians in addition to this ethical dilemma. Physicians are subject to criminal penalties and civil liability under the Act if they fail to comply with the Act's notice requirements despite the existence of a medical emergency. *See* N.H. Rev. Stat. Ann. § 132:27. Yet, if they fail to treat a patient in a medical emergency, they may also be subject to civil liability for negligence. The Act thus places physicians in an untenable position, caught between competing legal mandates.

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[64] *See* American Medical Association, H-60.965: *Confidential Health Services for Adolescents* and E-5.059, *Privacy in the Context of Health Care* ("Physicians must seek to protect patient privacy in all of its forms[.]"), *available at* http://www.ama-assn.org/ama/noindex/category/11760.html; *see also* AAP Committee on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 Pediatrics 746 (May 1996); American College of Obstetricians & Gynecologists, *ACOG Statement of Policy: Access to Reproductive Health Care for Adolescents* (July 2000).

II. A MEDICAL-EMERGENCY EXCEPTION WILL PROTECT, NOT ENDANGER, YOUNG WOMEN'S HEALTH

A. A Medical-Emergency Exception Will Not Prevent Physicians From Involving a Minor's Parent Where Appropriate

In the absence of parental notification or consent laws, the majority of pregnant teens involve one or both parents in their decision about whether to have an abortion or continue an unintended pregnancy.[65] Physicians or clinic staff frequently offer to act as an intermediary for a minor who is reluctant to tell her parents that she is pregnant.[66] The existence of a medical-emergency exception in a law mandating parental involvement does not prevent a physician from contacting a parent in a health emergency if the circumstances permit. Rather, a medical-emergency exception merely provides physicians with a mechanism to treat critically ill patients with necessary speed where the delay in notifying a parent, or obtaining a court order, will itself endanger the patient's health.

B. Parental Involvement Is Not Necessary To Provide Safe Abortion Care to a Minor, Even in a Medical Emergency

Parental involvement is not a necessary requirement for safe abortion care. In fact, physicians regularly provide safe abortion care to minors without parental involvement. Mi-

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[65] Studies have found that the vast majority of teens having an abortion do so with the knowledge of at least one parent. *See* Alan Guttmacher Institute, *Induced Abortion*, *supra* note 38 (61% of minors having an abortion do so with the knowledge of at least one parent); AAP Committee on Adolescence, *supra* note 64, at 747 (90% of adolescents 14 years old or younger and 74% of adolescents 16 years old or younger had an abortion with the knowledge of at least one parent).

[66] Indeed, "a discussion about involving [a teen's] parent or guardian in the abortion decision" is part of the typical abortion provider's informed consent process. Anna Baker et al., *Informed Consent, Counseling, and Patient Preparation*, in *A Clinician's Guide to Medical and Surgical Abortion* 35 (Maureen Paul, MD, et al. eds., 1999) ("*Clinician's Guide*").

nors are capable of providing meaningful, informed consent to medical care, including abortion.[67] And, in approximately one-third of states (including New Hampshire until now), pregnant minors may consent to abortion care without parental involvement.[68] No evidence indicates that lack of parental involvement endangers minors' health; if anything, studies show that parental involvement laws may place teenagers at risk by causing them to delay their abortions.[69]

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[67] Nancy E. Adler et al., *Abortion Among Adolescents*, Am. Psychol. 211, 213-214 (Mar. 2003). In implicit recognition of minors' capacity to make reproductive healthcare decisions, leading medical and public health groups (including *amici* AMA, AAP, ACOG, APHA, and SAM) have adopted policies supporting a minor's right to confidential access to health services, including abortion, without state-mandated parental involvement. *See supra* note 64; American Public Health Ass'n, *Policy Statement 9001: Adolescent Access to Comprehensive, Confidential Reproductive Health Care, reprinted in* 81 Am. J. Pub. Health 241 (Feb. 1991); Society for Adolescent Medicine, *Confidential Health Care for Adolescents*, 21 J. Adolescent Health 408 (1997).

[68] Connecticut, Hawaii, New York, Oregon, Vermont, Washington and the District of Columbia have not enacted parental involvement laws. The laws in Alaska, California, Idaho, Illinois, Montana, Nevada, New Hampshire, New Jersey, and New Mexico are currently enjoined and thus not enforced. *See* Alan Guttmacher Institute, *State Policies in Brief: Parental Involvement in Minors' Abortions* (Sept. 23, 2005), *available at* http://www.agi-usa.org/statecenter/spibs/spib_PIMA.pdf.

[69] *See* Stanley K. Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, in *Clinician's Guide* 18.

Several of the State's *amici*'s claims regarding the alleged benefits of parental involvement laws are based on a misuse of statistical data. For example, while *amici* Minnesota and North Dakota cite low teen pregnancy rates in their states (*see* Minn. Br. 7-9), New Hampshire, which has never had such a law, ranks 48th out of the 50 states in teen pregnancy rate, virtually indistinguishable from Minnesota (47) and North Dakota (50) and far lower than Mississippi, which ranks third in the nation and has a law requiring consent of both parents prior to a minor's abortion. *See* Alan Guttmacher Institute, *U.S. Teen Pregnancy Statistics: Overall Trends, Trends by Race and Ethnicity, And State-by-State Information* 8-11 (Feb. 19, 2004), *available at* http://www.guttmacher.org/pubs/state_pregnancy_trends.pdf. Similarly, Minnesota cherry picks three states (Minnesota, North Dakota, and California) to support its claim that parental involvement laws decrease the rate of minors who become preg-

Abortion is safe and relatively straightforward from a medical perspective. Abortion has an extremely low complication rate (complications requiring hospitalization result in 0.27% or fewer of cases).[70] The risk of death due to complications from pregnancy or childbirth is ten times greater than the risk of fatality from an abortion.[71]

The absence of parental involvement does not make abortion less safe. "The medical evaluation of a woman seeking abortion is seldom complicated," and the teen is able to provide information needed for an adequate medical history.[72] The most salient fact for a safe abortion is accurate knowledge of the date of the teen's last menstrual period, which is more likely to be known to the teen than to her parent, and is, in any event, almost never known *only* to her parent. The physician or clinic is also able to verify that date independently with various methods such as a pelvic examination, clinical sizing of the uterus, or by ultrasonography.[73]

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nant by older men. *See* Minn. Br. 5-6. But three other states could be chosen to prove the opposite. For example, New Hampshire's rate of teen mothers with a partner four or more years older (34%) is slightly lower than Mississippi's (35%) or Rhode Island's (40%), two states with mandatory parental involvement laws. And, a comparison of all states shows that there is no substantive difference between the percentage of births to minors where the father was four or more years older in states with parental involvement laws and states without such laws. *See Fathers' Ages: Child Trends, Facts At a Glance* (Mar. 2005), *available at* http://www.childtrends.org/files/Facts_2005.pdf.

[70] Studies indicate that serious complications from a surgical abortion, requiring hospitalization, occur in anywhere from 0.07% of patients (study of 170,000 first-trimester abortions performed between 1971 and 1987) to 0.08% (information maintained by the National Abortion Federation ("NAF") of 240,000 abortions performed at all gestational ages) to .27% (NAF information on approximately 72,000 abortions where patient follow-up was reported). *See* Henshaw, *supra* note 69, at 20.

[71] *See id.*

[72] D. Scott Poehlmann, MD & Bruce Ferguson, MD, *Medical Evaluation and Management*, in *Clinician's Guide* 53.

[73] *See* Steven R. Goldstein, MD, et al., *Documenting Pregnancy and Gestational Age*, in *Clinician's Guide* 41.

Other relevant medical facts for abortion care—current health and previous health problems, history of sexually transmitted diseases (STDs), and recent or current substance abuse—are types of information that a minor is likely to know but may not have disclosed to a parent.[74]

Similarly, follow-up care for an abortion generally does not require parental involvement. Patients "may return to their normal daily activities when they feel ready . . . generally within hours or 1-2 days following a first trimester abortion."[75] Patients are also briefed on the warning signs for complications (heavy bleeding, fever, or persistent pain), all of which will be evident to the patient but not necessarily to her parents—even if informed about the abortion.[76]

The existence of a medical-emergency exception also does not prevent a physician from notifying a parent after the fact if the minor's specific circumstances make parental involvement in follow-up care critical to the minor's recovery. A statute that imposes a mandatory delay in treatment in a health emergency so that a parent can be notified in advance is not an appropriate way to meet the altogether different goal of parental involvement in follow-up care.[77]

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[74] *See* Poehlmann, *supra* note 72, at 53. In fact, the State and its *amici* are unable to provide any sound examples of information relevant to abortion care that would be known to a parent but not to the minor. Their one possibly relevant example is that a minor may not be aware that her mother has had breast cancer, *see* Eagle Forum Br. 3, but the abortion-breast cancer link has been thoroughly discredited. *See infra* note 81.

[75] Kathleen M. McIntosh, RN, et al., *Routine Aftercare and Contraception*, in *Clinician's Guide* 188.

[76] For examples, patients are told to contact the provider if they experience heavy bleeding, described in layperson's terms as "twice the normal menstrual flow." *Id.* A teen will be able to evaluate whether her bleeding is excessive under this standard, which is calibrated to her personal experience, but her parents would not.

[77] New Hampshire advocates for use of the judicial bypass mechanism in a medical emergency. But this, too, leaves the minor without parental involvement in follow-up care.

The State's argument that parental involvement is necessary in a medical emergency in the abortion context is inconsistent with the fact that doctors routinely treat minors without parental involvement in other emergency contexts.[78] Thus, in New Hampshire, and throughout the country, doctors routinely provide a wide range of medical services—including surgery and other medical procedures with similar or greater risks than abortion—to minors without prior parental involvement in emergency situations.

C. The Evidence Belies Any Serious Long-Term Health Consequences of Abortion for Minors

Contrary to the claims of the State and its *amici*, there is simply no reliable evidence that abortions are harmful to minors' health. Extensive reviews have concluded that there are no documented negative psychological or medical sequelae to abortion among teen-aged women.[79] Minors who obtain an abortion are not at greater risk of complications in future pregnancies,[80] future medical problems,[81] or future psychological problems.[82]

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[78] *See* James M. Morrissey et al., *Consent and Confidentiality In the Health Care of Children and Adolescents: A Legal Guide* 50-51, 53 (The Free Press 1986); Fay A. Rosovsky, *Consent to Treatment: A Practical Guide* § 5.2.1 (Aspen Pub. 3d ed. 2001); Angela Roddey Holder, *Legal Issues in Pediatrics and Adolescent Medicine* 125-126 (Yale Univ. Press 1985); Abigail English & Kirsten E. Kenney, Center for Adolescent Health & the Law, *State Minor Consent Laws: A Summary* iv (2d ed. 2003).

[79] AAP Committee on Adolescence, *supra* note 64, at 748 (discussing first-trimester abortions, which account for more than 90% of U.S. abortions). Overall "data do not suggest that legal minors are at heightened risk of serious adverse psychological responses compared with adult abortion patients or with peers who have not undergone abortion." Adler et al., *supra* note 67, at 213.

[80] There is no evidence of complications in future pregnancies among women who have had a first-trimester vacuum aspiration abortion, the most common procedure. *See Induced Abortion*, *supra* note 38, at 2; Henshaw, *supra* note 69, at 20 ("A review of all studies that met basic criteria for methodological adequacy found no statistically detectable effect of first trimester suction abortion on secondary infertility, ectopic pregnancy,

midtrimester spontaneous abortion, prematurity, or low birth weight."). Several *amici* claim that induced abortion increases the risk of placenta previa in future pregnancies, but rely on "[p]ast studies [that] did not take into account the method of abortion[.]" Johnson, *supra* note 28, at 196. Women who have multiple abortions by the nearly obsolete sharp curettage method may have a slightly increased risk of placenta previa, but there is no risk associated with the vacuum aspiration or D&E methods that are currently used. *Id.* at 196-197.

[81] The only medical risk cited by the State's *amici* is the alleged risk of breast cancer, a risk that even they admit is "disputed." *See* U.S. Conf. Catholic Bishops Br. 18. The claim that abortion increases the risk of breast cancer has, in fact, been thoroughly debunked. *See* Carol J. Rowland et al., *Answering Questions About Long-Term Outcomes*, in *Clinician's Guide* 221-222 (discussing studies on the purported abortion-breast cancer linkage, including a study of 1.5 million finding "no overall increased risk of breast cancer . . . demonstrated among women with a history of induced abortion."); Collaborative Group on Hormonal Factors in Breast Cancer, *Breast Cancer And Abortion: Collaborative Reanalysis of Data From 53 Epidemiological Studies*, 363 The Lancet 1007, 1014 (Mar. 27, 2004) ("Hence, the totality of the worldwide epidemiological evidence indicates that pregnancies ending as either spontaneous or induced abortions do not have adverse effects on women's subsequent risk of developing breast cancer.").

Other *amici* claim that, because "early" childbirth reduces the risk of breast cancer, a teenager who has an abortion misses out on this "protective effect." *See, e.g.*, Alaska Br. 9, n.11; Ass'n of Am. Physicians & Surgeons Br. 12; Eagle Forum Br. 14. But "early" childbirth is defined as birth of a first child before the age of 25, and with risk of breast cancer rising only for women who first give birth after age 30. *See* G. Albrektsen et al., *Breast Cancer Risk by Age at Birth, Time Since Birth and Time Intervals Between Births: Exploring Interaction Effects*, 92 Br. J. Cancer 167, 169 (2005). It hardly makes sense to suggest that preventing minors from obtaining abortions is the best way to obtain a protective effect that occurs up to age 30.

[82] *Amicus* APA has concluded after careful study that there are no mental health syndromes linked to abortion. *Improving Women's Health: Understanding Depression After Pregnancy* (Sept. 29, 2004) (statement of Nada L. Stotland, M.D., M.P.H.), *available at* http://energycommerce.house.gov/108/Hearings/09292004hearing1388/Stotland2227.htm; *see also* Rowland, *supra* note 81, at 223 ("[T]here is no convincing evidence of significant negative psychological sequelae from induced abortion."). The lack of negative mental health effects associated with the decision to have an abortion holds true for adolescents. *See* Adler et al., *supra* note 67, at 212 ("Well-designed studies of psychological studies following abortion

III. Statutory Medical-Emergency Exceptions Are Not Used Inappropriately or Abused

Given the inability to dispute that there is a medical need for emergency abortions in certain circumstances, the objection raised by several of New Hampshire's *amici* to a medical-emergency exception in the Act appears to amount to a concern that it would serve as a loophole to allow physicians to avoid notifying parents in any situation. N.H. Legislators Br. 24-25. But there is simply no evidence that physicians would operate in this manner, nor any basis for suggesting that physicians cannot be trusted to follow the law. Indeed, the statistics marshaled by the State's *amici* give lie to the claim that statutory medical-emergency exceptions are massive loopholes used by physicians to evade legal requirements.[83]

IV. Adopting the *Salerno* Standard in the Context of Medical Emergencies Would Endanger Minors' Health

A. An "As-Applied" Challenge Offers No Meaningful Relief in the Context of a Medical Emergency

Were the standard for facial challenges articulated in *United States* v. *Salerno*, 481 U.S. 739 (1987), to govern here, as New Hampshire and its *amici* urge, minors' health would be compromised. In practice, application of the *Salerno* rule—under which a statute must be upheld unless there is "no set of circumstances" in which it could be applied constitutionally—would mean that virtually any abortion regulation, including the Act, would survive a facial challenge. *Salerno* would thus effectively leave as-applied

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have consistently shown that risk of psychological harm is also low," with "postabortion rates of distress and dysfunction . . . lower than preabortion rates."); Jackie Tillett, *Adolescents and Informed Consent*, 19 J. Perinat. Neonat. Nurs. 112, 114 (2005).

[83] *See* Thomas More Society Br. 12-22 (in the six states that require reporting of abortions which relied on an emergency exception, only thirteen such abortions occurred).

challenges as the only means of attacking constitutionally infirm abortion restrictions like the Act. But such challenges offer no meaningful relief in the context of a medical emergency.

When pregnant minors face the serious conditions described above, *see supra* pp. 6-11, time is of the essence. Just as the Act's judicial bypass mechanism is inherently too slow to deal with these critical health emergencies, so too is an as-applied legal challenge. In cases of chorioamnionitis, preeclampsia, HELLP, or severe bleeding from placental abruption or previa, even short delays in treatment can be catastrophic.[84] Physicians treating patients with these conditions often must make medical decisions in a matter of hours. The time required to mount an as-applied challenge and to obtain judicial relief will cost a patient critical time in a medical emergency.[85]

B. Adopting the *Salerno* Standard Would Chill Physicians' Willingness To Perform Abortions

Because as-applied challenges are not a meaningful alternative to a medical-emergency exception, were facial challenges to be precluded, the Act would place physicians and their patients in an untenable situation with grave consequences for young women's health. Without the protection of a medical-emergency exception, physicians will be forced to place themselves in legal jeopardy to provide appropriate care to their patients in the hope that an after-the-fact assessment by a court will conclude that the law was unconstitutional as applied to that case. But doctors should not be required to compromise their best medical judgment

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[84] *Critical Care Obstetrics* 298-299, 438, 562-564; *Emergency Medicine* 1322.

[85] The United States appears to concede that a pre-enforcement as-applied challenge would likely not be resolved in time to provide comfort to a physician or patient in a medical emergency. It suggests that, given the exceptions to mootness rules, the suit could proceed "even after the woman had an abortion" (U.S. Br. 16), acknowledging that such challenges do not offer timely relief.

out of concern for their own freedom. The specter of criminal liability will have a profound chilling effect on physicians' willingness to perform abortions even in circumstances where the legislation cannot constitutionally apply. *See Colautti* v. *Franklin*, 439 U.S. 379, 396 (1979) (recognizing the potential for a "profound chilling effect on the willingness of physicians to perform abortions . . . in the manner indicated by their best medical judgment").

The United States and New Hampshire incorrectly argue that as-applied challenges offer all the relief that is needed to avoid the detrimental health consequences posed by a statute that is unassailable through facial challenges. *See* U.S. Br. 14; Pet. Br. 41. Not only are these arguments fundamentally flawed, but the proposed solutions compromise the very principles that the United States and New Hampshire purport to advance.

In suggesting that as-applied challenges offer sufficient relief, the United States assumes that the relief sought in one challenge would have some impact on future cases, via *stare decisis* or otherwise. But *stare decisis* cannot be expected to overcome the chilling effect on physicians, as the very nature of an as-applied challenge, even if it occurs prior to enforcement of the act, limits the holding to the circumstances of the particular case. Doctors will likely not know the details of each adjudicated challenge and, even if they did, medical conditions are too variable and each patient's health circumstances too unique for a decision in one case to offer a clear directive to doctors in the next. Given this uncertainty, a prior case would not help overcome the specter of liability posed by the Act and thus would not comfort physicians treating critically ill patients.

The United States mentions class actions to suggest that broader relief is somehow available, but it entirely fails to spell out how a class action would work and how it would offer the necessary relief to preserve women's health. *See* U.S. Br. 15. It is not surprising that the United States fails to provide these details given the inherent difficulties in relying on class actions in these circumstances. Class actions

present the same problem of delay in time-sensitive medical emergencies as do as-applied challenges. But even if a class could be certified, physicians would not have the requisite certainty that their patients would qualify for class membership to provide them with legal assurance in a medical emergency.

Perhaps most importantly, both *stare decisis* and class relief fail to serve the very interests that the United States and New Hampshire purport to advance. If a class action, or *stare decisis* generally, is to be broad enough to provide physicians and patients with sufficient clarity for future cases then these approaches are no more limited or concrete than the facial challenge that New Hampshire and its *amici* decry. Yet if such relief is crafted narrowly, it will provide no protection for physicians treating patients in future medical emergencies.

V. The Act's Death Exception Is Insufficient To Protect Minor's Health

The exception provided in the Act for situations that threaten a minor's life is unconstitutionally and unconscionably narrow. The Act permits a doctor to perform a life-saving abortion on a minor without delay only if the doctor *certifies in writing* that an "abortion is necessary to prevent the minor's death and there is insufficient time to provide the required notice." N.H. Rev. Stat. Ann. § 132:26.I(a). The exception is thus limited to conditions that are *certain* to cause a minor's death within the forty-eight hours the Act mandates for parental notice. It does not cover conditions that the doctor believes are likely to cause death, conditions that are possibly—but not definitely—fatal, or conditions that are certain to cause death, but may not do so within forty-eight hours.

These limitations betray a misunderstanding of how medicine is practiced. Doctors cannot predict what course medical complications will take in a given emergency situation with precision. They will rarely be able to certify in writing that a patient will die in less than forty-eight hours

absent an abortion, yet an abortion is no less necessary in these circumstances to preserve the patient's life or health.

Moreover, as the First Circuit correctly concluded, the Act's death exception "fails to safeguard a physician's good-faith medical judgment that a minor's life is at risk against criminal and civil liability." 390 F.3d at 64. There is nothing in the Act or New Hampshire law that would prevent a physician from being prosecuted or sued on the grounds that a particular abortion procedure he or she certified and performed was not "necessary" under the circumstances. Moreover, a doctor cannot know whether his or her certification will be judged according to a standard that simply evaluates whether he or she acted in good faith based on his or her own best medical judgment or according to an objective standard that allows judges and juries to second-guess the reasonableness of that judgment.[86] This threat of criminal prosecution and civil liability will significantly hamper doctors treating minors who need life-saving abortions. It thus puts minors' lives at risk.

CONCLUSION

For the foregoing reasons, and those stated in the briefs of Respondent and its other *amici*, the decision of the Court of Appeals should be affirmed.

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[86] Contrary to the assertion that a doctor is immune from liability if he or she acts in good faith on his or her subjective professional opinion (*see* U.S. Br. 29), there is a real possibility that a doctor's determination would be evaluated under an objective standard. *See* 390 F.3d at 63-64. Under New Hampshire law, a person is guilty of a misdemeanor only if he acts "purposely, knowingly, recklessly, or negligently" with respect to each element of the offense. N.H. Rev. Stat. Ann. § 626:2.I. The definition of negligence imposes an objective standard of reasonableness. *See id.* § 626:2.II(d).

Respectfully submitted.

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